STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN47170

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F0000	This visit was for the Investigation of Complaint IN00086763, Complaint IN00087154, and Complaint IN00087163. Complaint IN00086763 - Unsubstantiated, due to lack of evidence. Complaint IN00087154 - Unsubstantiated, due to lack of evidence. Complaint IN00087163 - Substantiated. Federal/State deficiencies are cited at F224, F225 and F226. Unrelated deficiency cited. Survey dates: March 8, 9, and 10, 2011 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 5 Medicaid: 64 Other: 4	F0000	Preparation and/or execution of this plan of correction in genreal, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deciciencies. The plan of correction and specific corrective and specific coreective actions are prepared and/or executed in compliance with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 73 Sample: 9 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/15/11 by Suzanne Williams, RN			

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F0224 SS=D	Based on interview and record review, the facility failed to ensure a resident was free from mistreatment [Resident G], for 1 of 4 residents reviewed for abuse, in a sample of 9. Findings include: On 3/8/11 at 10:15 A.M., the Director of Nursing [DoN] provided the current facility policy, dated 1/07, on Abuse Prevention. The policy included, "It is the policy of this facility to keep residents free from physical, mental, sexual, verbal and psychological abuse at all times. Preventing abuse, neglect...is one of the primary responsibilities of the long-term care facility. The facility has provided training for residents, families, and staff to prevent and prohibit abuse events, along with ongoing education...." The clinical record of Resident G was reviewed on 3/9/11 at 10:30 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbance, Alzheimer's disease, mood disorder, and anxiety. The most recent Minimum Data Set [MDS] assessment, dated 1/28/11, indicated Resident G scored a 1 out of 15 in a cognitive assessment, and was totally	F0224	F224 PROHIBITMISTREATMENT/NEGLECT/MISAPPROPRIATIONIt is the intent of this facility to ensure all residents' remain free of mistreatment.1. Actions Taken:A. In regards to Resident # G, the Licensed Nurse identified was terminated on 2/23/11.2. Residents Identified:A. No other allegations of abuse have been reported.3. Measures Taken:A. All staff were in-serviced on the facility Abuse Policy and Procedure and reporting requirements and all forms/types of abuse were reviewed.4. How Monitored:A. DON/Designee will immediately notify of, and review with the Administrator, all allegations of abuse as any occur, to ensure compliance with the Abuse policy/procedure and the safety of all residents.B. ADM/Designee will review all allegations/investigations during daily QA meeting to ensure and be responsible for on-going compliance.C. Administrator will review allegations/investigations with the Medical Director at Quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 25, 2011.	03/25/2011

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	dependent on one staff for dressing, hygiene and bathing. The MDS assessment indicated Resident G was frequently incontinent of bowel and bladder. On 3/8/11 at 11:00 A.M., the Director of Nursing provided a copy of an abuse investigation faxed to the Indiana State Department of Health, dated 2/23/11. The investigation included: "...Incident Date, 2-20-11, Incident Time, Unknown, Resident Name [Resident G]...Diagnoses, Dementia...Alzheimer's...Brief Description of Incident, [LPN # 1] told another nurse that he sat Resident down in chair 'hard.' Type of Injury/Injuries, none sustained. No bruises to buttocks. No emotional distress noted...Preventative Measures Taken, Re-inservice and Re-educate staff on abuse policy [and] timely reporting...2/23/11 - LPN terminated. Investigation carried out by DON, ADON [Assistant Director of Nursing], Adm. [Administrator], Allegation - unable to substantiate..." An attached typed statement by the DoN, dated 2/22/11, indicated, "Spoke with [CNA # 1] the CNA who worked with [LPN # 1] on Sunday 2-20-11 when allegation was suppose [sic] to take place. She stated that [Resident G] had slept			

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	most of night and when he awoke he was somewhat combative. She said that [LPN # 1] took the resident to his room. When [LPN # 1] came out of the room [CNA # 1] said he was very mad, and said [Resident G] locked his elbow and then fell to the ground. He said that he knew [Resident G] was trying to break his arm. [CNA # 1] then went on to say that [LPN # 1] said in a sarcastic voice, 'So I had to gently place him in his chair.' She did not witness anything, but did say [LPN # 1] was very upset, and was sarcastic when he said 'Gently.'" An additional typed statement by the DoN, dated 2/22/11, indicated, "...Received a note from charge nurse [LPN # 2] on this date. He stated that [LPN # 3] brought to his attention that on Sunday night [LPN # 1] told [LPN # 3] that he had just slammed [Resident G] in a chair. Placed call to [LPN # 3] at this time and questioned her on the events of Sunday night. She stated that [LPN # 1] came off of the unit and proceded [sic] to tell her that [Resident G] had just locked [LPN # 1's] elbow in with his and he tried to remove [Resident G] from his arm... [LPN # 1] went on to say that he picked [Resident G] up and slammed him in a chair, and then said well no maybe I sat him down a little hard. She said [LPN # 1]			

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	was very angry....Educated [LPN # 3] on allegations of abuse. Informed her that any allegation needs to be reported to on call manager at that time so we can begin investigation immediately and send the staff member home. She voiced understanding. I repeated out [sic] abuse policy and how to intervene and follow up on all allegations." The DoN indicated at that time that LPN # 3 should have immediately reported the incident to her, and was inserviced. The DoN indicated the CNA involved "really didn't witness anything." The DoN indicated the nurse manager was the person who informed her on 2/22/11. On 3/9/11 at 3:10 P.M., CNA # 1 was interviewed regarding Resident G's incident on 2/20/11. CNA # 1 indicated, "I had stepped off of the unit. [LPN # 1] told me and [LPN # 3] that he took care of [Resident G]. I wasn't sure what he meant. [LPN # 1] can be sarcastic. He told me and the other nurse about it at the same time. He said he took [Resident G] to his room and put him in his chair. [LPN # 1] said [Resident G] should start to calm down now." On 3/9/11 at 10:15 P.M., LPN # 3 was interviewed regarding Resident G's incident on 2/20/11. LPN # 3 indicated,			

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	"There were only two nurses here, and then one aide on that unit. [LPN # 1] came out and told me that he slammed [Resident G] down and set him down hard." LPN # 3 indicated LPN # 1 was very angry. LPN # 3 indicated she told LPN # 2 about the incident "when he found the bruises on his arms." LPN # 3 indicated she thought LPN # 2 then wrote a letter to the DoN. On 3/10/11 at 9:30 A.M., during interview, the DoN indicated she performed a thorough skin assessment on Resident G on 2/22/11. The DoN indicated the resident had multiple bruised areas on his arms from admission, and had fallen a few days previous to that, which may have caused additional bruising. The DoN indicated she focused on potential bruising to the buttocks, due to the statement of "sitting down hard." On 3/10/11 at 1:05 P.M., during interview, the DoN indicated she received a letter that LPN # 2 had written on 2/21/11 regarding the alleged abuse on 2/22/11, and had also inserviced LPN # 2 regarding the facility's abuse procedure. This federal tag relates to Complaint IN00087163.			

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F0225 SS=D	Based on interview and record review, the facility failed to ensure staff reported immediately to the Administrator an incident of alleged physical abuse from a staff member to a resident [Resident G], and immediately reported a resident's large area of bruising of an unknown origin [Resident C], for 2 of 4 residents reviewed for abuse, in a sample of 9. Findings include: 1. On 3/8/11 at 10:15 A.M., the Director of Nursing [DoN] provided the current facility policy, dated 1/07, on "Response to Suspected Abuse, Neglect, Mistreatment, or Misappropriation of Resident Property." The policy included: "...All allegations of abuse must be taken seriously and must be investigated. The reporting and investigation policies and procedures must be fully enforced...Abuse can be manifested in various, subtle ways...Some examples include: Physical Evidence:...the source of the injury was not observed by any person or the source of the injury could not be explained by the resident: AND the injury is suspicious because of the extent of the injury or the location of the injury...All incidents resulting in an injury must be fully investigated to determine the cause of the incident and how to prevent recurrence in	F0225	F225 Investigate/report allegations/individualsIt is the intent of this facility for staff to report immediately to the Administrator, violations involving mistreatment, neglect, or abuse, and residents are protected, and it is reported per the requirements. This includes all alleged physcial abuse from a staff member to a resident and all resident's identified with large areas of bruising of an unknown origin1. Actions Taken:A. In regards to Resident G, an investigation was completed and the allegation of abuse could not substantiated but the suspect LPN was terminated 2/23/11.B. In regards to Resident C, an investigation was completed with a finding that the discoloration was self inflicted. Interventions were put in place. Resident C has since had a pre-planned discharge to another facility.2. Residents Identified:A. No other investigations have been initiated and no other reports of abuse have been made.3. Measures Taken:A. All Department heads in-serviced on Abuse Protocol and policy/procedure; including the immediate notification of the Administrator.B. In-services conducted for all staff related to abuse policy including immediate notification of the Administrator and removing accused personnel from the facility during the	03/25/2011

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	the future...Any alleged violation involving mistreatment...abuse, neglect...shall be immediately reported to the Administrator, Director of Nursing or designee(s)...." 2. On 3/8/11 at 11:00 A.M., the Director of Nursing provided a copy of an abuse investigation faxed to the Indiana State Department of Health, dated 2/23/11. The investigation included: "...Incident Date, 2-20-11, Incident Time, Unknown, Resident Name [Resident G]...Diagnoses, Dementia...Alzheimer's...Brief Description of Incident, [LPN # 1] told another nurse that he sat Resident down in chair 'hard.' Type of Injury/Injuries, none sustained. No bruises to buttocks. No emotional distress noted...Preventative Measures Taken, Re-inservice and Re-educate staff on abuse policy [and] timely reporting...2/23/11 - LPN terminated. Investigation carried out by DON, ADON [Assistant Director of Nursing], Adm. [Administrator], Allegation - unable to substantiate..." An attached typed statement by the DoN, dated 2/22/11, indicated, "Spoke with [CNA # 1] the CNA who worked with [LPN # 1] on Sunday 2-20-11 when allegation was suppose [sic] to take place. She stated that [Resident G] had slept		investigation, etc.4. How Monitored:A. DON/IDT will immediately notify the Administrator and review/report all abuse allegations as any occur, to ensure compliance with abuse policy/procedure and reporting guidelines.B. ADM/IDT will review all allegations of abuse, when and if any occur, during daily QA stand-up meeting to ensure and be responsible for on-going compliance.C. All Investigations and results will be reviewed with the Medical Director at Quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 25, 2011.	

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	most of night and when he awoke he was somewhat combative. She said that [LPN # 1] took the resident to his room. When [LPN # 1] came out of the room [CNA # 1] said he was very mad, and said [Resident G] locked his elbow and then fell to the ground. He said that he knew [Resident G] was trying to break his arm. [CNA # 1] then went on to say that [LPN # 1] said in a sarcastic voice, 'So I had to gently place him in his chair.' She did not witness anything, but did say [LPN # 1] was very upset, and was sarcastic when he said 'Gently.'" An additional typed statement by the DoN, dated 2/22/11, indicated, "...Received a note from charge nurse [LPN # 2] on this date. He stated that [LPN # 3] brought to his attention that on Sunday night [LPN # 1] told [LPN # 3] that he had just slammed [Resident G] in a chair. Placed call to [LPN # 3] at this time and questioned her on the events of Sunday night. She stated that [LPN # 1] came off of the unit and proceded [sic] to tell her that [Resident G] had just locked [LPN # 1's] elbow in with his and he tried to remove [Resident G] from his arm... [LPN # 1] went on to say that he picked [Resident G] up and slammed him in a chair, and then said well no maybe I sat him down a little hard. She said [LPN # 1]			

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	was very angry....Educated [LPN # 3] on allegations of abuse. Informed her that any allegation needs to be reported to on call manager at that time so we can begin investigation immediately and send the staff member home. She voiced understanding. I repeated out [sic] abuse policy and how to intervene and follow up on all allegations." The DoN indicated at that time that LPN # 3 should have immediately reported the incident to her, and was inserviced. The DoN indicated the CNA involved "really didn't witness anything." The DoN indicated the nurse manager was the person who informed her on 2/22/11. On 3/9/11 at 3:10 P.M., CNA # 1 was interviewed regarding Resident G's incident on 2/20/11. CNA # 1 indicated, "I had stepped off of the unit. [LPN # 1] told me and [LPN # 3] that he took care of [Resident G]. I wasn't sure what he meant. [LPN # 1] can be sarcastic. He told me and the other nurse about it at the same time. He said he took [Resident G] to his room and put him in his chair. [LPN # 1] said [Resident G] should start to calm down now." On 3/9/11 at 10:15 P.M., LPN # 3 was interviewed regarding Resident G's incident on 2/20/11. LPN # 3 indicated,			

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	"There were only two nurses here, and then one aide on that unit. [LPN # 1] came out and told me that he slammed [Resident G] down and set him down hard." LPN # 3 indicated LPN # 1 was very angry. LPN # 3 indicated she told LPN # 2 about the incident "when he found the bruises on his arms." LPN # 3 indicated she thought LPN # 2 then wrote a letter to the DoN. On 3/10/11 at 9:30 A.M., during interview, the DoN indicated she performed a thorough skin assessment on Resident G on 2/22/11. The DoN indicated the resident had multiple bruised areas on his arms from admission, and had fallen a few days previous to that, which may have caused additional bruising. The DoN indicated she focused on potential bruising to the buttocks, due to the statement of "sitting down hard." On 3/10/11 at 1:05 P.M., during interview, the DoN indicated she received a letter that LPN # 2 had written on 2/21/11 regarding the alleged abuse on 2/22/11, and had also inserviced LPN # 2 regarding the facility's abuse procedure. 3. The closed clinical record of Resident C was reviewed on 3/9/11 at 12:10 P.M. Diagnoses included, but were not limited			

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	to, Dementia with Behavioral Disturbance. The resident was admitted to one of the locked units in the facility on 2/23/11. Nurses Notes included the following notations: 3/1/11 at 8:00 P.M.: "Called to rm [room] per CNA as dressing resident for bed found 2 lg [large] purple bruises. # 1 Lt [left] buttock to scrotum measures 14 x 6 cm [centimeters]. # 2 Rt. [right] lat. [lateral] thigh measures 9.5 x 5 cm. Resident unable to verbalize cause...Message left for DoN." 3/2/11 at 10:30 A.M.: "...Upon assessment for bruising on buttock et [and] thigh, bruising was found in anal area as well...." 3/2/11 at 11:30 A.M.: "This nurse was advised of bruises on res's [resident's] Rt. thigh et l [left] buttock by 2nd shift nurse in morning report...Res. was assessed...At this time swelling of [left] knee was noted...MD was phoned...." On 3/8/11 at 1:00 P.M., the DoN provided a "Faxed Incident Report," dated 3/2/11, regarding Resident C. The report included, "...Brief description of Incident,			

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	Area of discoloration noted from coccyx to scrotum...Investigation started. Complete assessment done to check for other areas...." Written statements by LPN # 4 and LPN # 5 were attached. On 3/9/11 at 10:55 A.M., LPN # 4 was interviewed regarding the bruising on Resident C. LPN # 4 indicated she worked the morning of 3/2/11. She indicated the night shift nurse reported Resident C had dark bruising. LPN # 4 indicated when she saw the bruising, she "was astounded," and immediately went and informed the DoN. LPN # 4 indicated the previous shift nurse had not notified the physician or family. LPN # 4 indicated the resident had "not fallen" that she was aware of, but that the bruising indicated "he had to have fallen hard and with some force." On 3/9/11 at 2:30 P.M., the DoN indicated she had not received a message related to the resident's bruising on 3/1/11. The DoN indicated she was "not even the person on call that night." This federal tag relates to Complaint IN00087163. 3.1-28(d)			

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F0226 SS=D	Based on interview and record review, the facility failed to ensure staff reported immediately to the Administrator an incident of alleged physical abuse from a staff member to a resident [Resident G], and immediately reported a resident's large area of bruising of an unknown origin [Resident C]; and failed to ensure the policy for abuse was specific for ensuring the Administrator was immediately informed of allegations, for 2 of 4 residents reviewed for abuse, in a sample of 9. Findings include: 1. On 3/8/11 at 10:15 A.M., the Director of Nursing [DoN] provided the current facility policy, dated 1/07, on "Response to Suspected Abuse, Neglect, Mistreatment, or Misappropriation of Resident Property." The policy included: "...All allegations of abuse must be taken seriously and must be investigated. The reporting and investigation policies and procedures must be fully enforced...Abuse can be manifested in various, subtle ways...Some examples include: Physical Evidence:...the source of the injury was not observed by any person or the source of the injury could not be explained by the resident: AND the injury is suspicious because of the extent of the injury or the	F0226	F226 Develop and Implement/Abuse/Neglect, etc. PoliciesIt is the intent of this facility for staff to report immediately to the Administrator, any/all alleged violations involving mistreatment, neglect, or abuse, including physcial abuse from a staff member to a resident, and any identified large areas of bruising of an unknown origin. It is also the intenet of this facility for the policy for abuse to be specific for immediately informing the Administrator of all allegations of abuse.1. Actions Taken:A. All Department heads in-serviced on Abuse Protocol and policy/procedure; including immediate notification of the Administrator of all allegations of abuse; including physical abuse from a staff member to a resident and any identified large areas of bruising of an unknown origin. 2. Residents Identified:A. No other residents have been identified, and no other reports of abuse have been made.3. Measures Taken:A. In-services conducted for all staff on Abuse Protocol and Abuse Policy and Procedure; including immediate notification of the Administrator of all allegations of abuse; such as, physical abuse from a staff member to a resident and any identified large areas of bruising of an unknown origin.4. How Monitored:A. DON/IDT will immediately notify the Administrator to report/review all	03/25/2011

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	location of the injury...All incidents resulting in an injury must be fully investigated to determine the cause of the incident and how to prevent recurrence in the future...Any alleged violation involving mistreatment...abuse, neglect...shall be immediately reported to the Administrator, Director of Nursing or designee(s)...." 2. On 3/8/11 at 11:00 A.M., the Director of Nursing provided a copy of an abuse investigation faxed to the Indiana State Department of Health, dated 2/23/11. The investigation included: "...Incident Date, 2-20-11, Incident Time, Unknown, Resident Name [Resident G]...Diagnoses, Dementia...Alzheimer's...Brief Description of Incident, [LPN # 1] told another nurse that he sat Resident down in chair 'hard.' Type of Injury/Injuries, none sustained. No bruises to buttocks. No emotional distress noted...Preventative Measures Taken, Re-inservice and Re-educate staff on abuse policy [and] timely reporting...2/23/11 - LPN terminated. Investigation carried out by DON, ADON [Assistant Director of Nursing], Adm. [Administrator], Allegation - unable to substantiate..." An attached typed statement by the DoN, dated 2/22/11, indicated, "Spoke with		abuse allegation as any occur, to ensure compliance with adhering to policy/procedure for abuse protocol. B. Administrator will review all investigations in daily QA meeting to ensure and be responsible for ongoing compliance. This will be ongoing.C. Administrator will be review all allegations/investigations with the Medical Director at the quarterly QA meeting. This will be on-going.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 25, 2011.	

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	[CNA # 1] the CNA who worked with [LPN # 1] on Sunday 2-20-11 when allegation was suppose [sic] to take place. She stated that [Resident G] had slept most of night and when he awoke he was somewhat combative. She said that [LPN # 1] took the resident to his room. When [LPN # 1] came out of the room [CNA # 1] said he was very mad, and said [Resident G] locked his elbow and then fell to the ground. He said that he knew [Resident G] was trying to break his arm. [CNA # 1] then went on to say that [LPN # 1] said in a sarcastic voice, 'So I had to gently place him in his chair.' She did not witness anything, but did say [LPN # 1] was very upset, and was sarcastic when he said 'Gently.'" An additional typed statement by the DoN, dated 2/22/11, indicated, "...Received a note from charge nurse [LPN # 2] on this date. He stated that [LPN # 3] brought to his attention that on Sunday night [LPN # 1] told [LPN # 3] that he had just slammed [Resident G] in a chair. Placed call to [LPN # 3] at this time and questioned her on the events of Sunday night. She stated that [LPN # 1] came off of the unit and proceded [sic] to tell her that [Resident G] had just locked [LPN # 1's] elbow in with his and he tried to remove [Resident G] from his arm...			

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	[LPN # 1] went on to say that he picked [Resident G] up and slammed him in a chair, and then said well no maybe I sat him down a little hard. She said [LPN # 1] was very angry....Educated [LPN # 3] on allegations of abuse. Informed her that any allegation needs to be reported to on call manager at that time so we can begin investigation immediately and send the staff member home. She voiced understanding. I repeated out [sic] abuse policy and how to intervene and follow up on all allegations." The DoN indicated at that time that LPN # 3 should have immediately reported the incident to her, and was inserviced. The DoN indicated the CNA involved "really didn't witness anything." The DoN indicated the nurse manager was the person who informed her on 2/22/11. On 3/9/11 at 3:10 P.M., CNA # 1 was interviewed regarding Resident G's incident on 2/20/11. CNA # 1 indicated, "I had stepped off of the unit. [LPN # 1] told me and [LPN # 3] that he took care of [Resident G]. I wasn't sure what he meant. [LPN # 1] can be sarcastic. He told me and the other nurse about it at the same time. He said he took [Resident G] to his room and put him in his chair. [LPN # 1] said [Resident G] should start to calm down now."			

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On 3/9/11 at 10:15 P.M., LPN # 3 was interviewed regarding Resident G's incident on 2/20/11. LPN # 3 indicated, "There were only two nurses here, and then one aide on that unit. [LPN # 1] came out and told me that he slammed [Resident G] down and set him down hard." LPN # 3 indicated LPN # 1 was very angry. LPN # 3 indicated she told LPN # 2 about the incident "when he found the bruises on his arms." LPN # 3 indicated she thought LPN # 2 then wrote a letter to the DoN.

On 3/10/11 at 9:30 A.M., during interview, the DoN indicated she performed a thorough skin assessment on Resident G on 2/22/11. The DoN indicated the resident had multiple bruised areas on his arms from admission, and had fallen a few days previous to that, which may have caused additional bruising. The DoN indicated she focused on potential bruising to the buttocks, due to the statement of "sitting down hard."

On 3/10/11 at 1:05 P.M., during interview, the DoN indicated she received a letter that LPN # 2 had written on 2/21/11 regarding the alleged abuse on 2/22/11, and had also inserviced LPN # 2 regarding the facility's abuse procedure.

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	3. The closed clinical record of Resident C was reviewed on 3/9/11 at 12:10 P.M. Diagnoses included, but were not limited to, Dementia with Behavioral Disturbance. The resident was admitted to one of the locked units in the facility on 2/23/11. Nurses Notes included the following notations: 3/1/11 at 8:00 P.M.: "Called to rm [room] per CNA as dressing resident for bed found 2 lg [large] purple bruises. # 1 Lt [left] buttock to scrotum measures 14 x 6 cm [centimeters]. # 2 Rt. [right] lat. [lateral] thigh measures 9.5 x 5 cm. Resident unable to verbalize cause...Message left for DoN." 3/2/11 at 10:30 A.M.: "...Upon assessment for bruising on buttock et [and] thigh, bruising was found in anal area as well...." 3/2/11 at 11:30 A.M.: "This nurse was advised of bruises on res's [resident's] Rt. thigh et l [left] buttock by 2nd shift nurse in morning report...Res. was assessed...At this time swelling of [left] knee was noted...MD was phoned...."			

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	On 3/8/11 at 1:00 P.M., the DoN provided a "Faxed Incident Report," dated 3/2/11, regarding Resident C. The report included, "...Brief description of Incident, Area of discoloration noted from coccyx to scrotum...Investigation started. Complete assessment done to check for other areas...." Written statements by LPN # 4 and LPN # 5 were attached. On 3/9/11 at 10:55 A.M., LPN # 4 was interviewed regarding the bruising on Resident C. LPN # 4 indicated she worked the morning of 3/2/11. She indicated the night shift nurse reported Resident C had dark bruising. LPN # 4 indicated when she saw the bruising, she "was astounded," and immediately went and informed the DoN. LPN # 4 indicated the previous shift nurse had not notified the physician or family. LPN # 4 indicated the resident had "not fallen" that she was aware of, but that the bruising indicated "he had to have fallen hard and with some force." On 3/9/11 at 2:30 P.M., the DoN indicated she had not received a message related to the resident's bruising on 3/1/11. The DoN indicated she was "not even the person on call that night." This federal tag relates to Complaint			

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F0248 SS=E	During observation, interview, and record review, the facility failed to ensure an activity program was implemented for 2 of 3 Alzheimer's units, with a combined census of 30 residents, out of a facility census of 73. (Ruby Bay and Emerald Brook Units) Findings include: On 3/8/11 at 9:50 A.M., during the initial tour, the Assistant Director of Nursing [ADON] indicated Ruby Bay was a locked Alzheimer's unit for women residents, and Emerald Brook was the facility's locked co-ed Alzheimer's unit. At that time, no activities were observed to be occurring on either unit. Most of the residents were either asleep in their beds, or asleep in chairs in the dining areas. On 3/8/11 at 10:55 A.M., no activities were observed on either of these two locked units. At 12:10 P.M., residents were observed getting ready to eat their lunch on each of the units. At 2:00 P.M., no activities were observed on either of these two units. Main activity calendars were not observed posted in these units. A weekly schedule was observed posted in the dining area on Ruby Bay, and in an activity room on Emerald Brook. The	F0248	F248 Activities Meet Interest/Needs of Each Resident:It is the intent of this facility to have an on-going activity program on all units.1. Actions Taken:A. In regards to Activities on Ruby Bay and Emerald Brook, another full time Activities person wil be implemented; allotting one full time person for each secure unit at a minimum of four hours per day.B. An Activity Calendar will be prominently displayed in an appropriate visual size, easily read by residents and staff on each Unit.2. OTHERS IDENTIFIED:A. Facility staff conducted a 100% audit of all facility residents on the other secured unit and the open unit to determine if activities of interest/need were available. No other Units/Residents were identified.3. MEASURES TAKEN:A. In-Serviced all nursing staff who work on secure units, in regards to expected activities participation with residents to be met on a daily and on-going basis. All nursing staff have been educated on keeping activity records and assisting resident while they pursue their interests. 4. HOW MONITORED:A. QA Team/IDT will monitor for activities on each unit during daily QA rounds; SS/AD will monitor/review activity participation during Resident Council meetings monthly with	03/25/2011

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	schedule included: "Tuesday: 9:00 -9:30 am Remember When, 9:30-10:00 am Exercise Walk Club, 10:00-10:45 am, Pretty Nails,Smokin Social, 12:30-2:00 pm Rest Time, Smokin Social, 2:00 - 3:00 pm I See Something, 3:00-4:00 pm Courtyard Games, Smokin Social...Wednesday: 10:00-10:45 am Bingo, Smokin Social, 12:30-2:00 pm, Rest Time, Smokin Social, 2:00-3:00 pm Hot Potato...Thursday, 9:00-9:30 am Parachute, 9:30-10:00 am Exercise, Walk Club...2:00-3:00 pm Name That Sound...." On 3/9/11, no activities were observed on either Ruby Bay or Emerald Brook at 10:40 A.M., 12:00 P.M., 2:30 P.M., or 4:00 P.M. On 3/10/11, no activities were observed on either Ruby Bay or Emerald Brook at 9:30 A.M. On 3/10/11 at 9:55 A.M., the Activities Director [AD] and Activities Assistant indicated, "It's hard for just the 2 of us to do all 4 units." The AD indicated, "The residents on Emerald really don't like to do much. They can come to BINGO. The aides usually take care of that." The AD indicated the main activities take place outside of the locked units, and the staff		the residents. This will be an on-going QA daily audit.B. Activity Staff will audit the Activity Records for Residents monthly for active/passive participation from residents. This will be reported to the QA Committee for review and suggestions monthly.C. Adm/Designee will review all audits at weekly QA meeting; and with Medical Director at quarterly QA meeting. This will be an on-going QA audit.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 25, 2011.	

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	could bring the residents to them if they wanted to come. The activity assistant indicated, "On my down time, I try and go visit those units." On 3/10/11 at 2:00 P.M., no activities were observed on the Ruby Bay or Emerald Brook units. 3.1-33(a)			